ALASKA STATE LEGISLATURE
SENATE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
May 3, 2004
1:36 p.m.

TAPE (S) 04-27&28

MEMBERS PRESENT

Senator Fred Dyson, Chair
Senator Lyda Green, Vice Chair
Senator Gary Wilken
Senator Bettye Davis
Senator Gretchen Guess

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

CS FOR HOUSE BILL NO. 511(HES) am
"An Act relating to the certificate of need program for health care facilities; and providing for an effective date."
HEARD AND HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 511
SHORT TITLE: CERTIFICATE OF NEED PROGRAM
SPONSOR(s): REPRESENTATIVE(s) SAMUELS

02/16/04	(H)	READ THE FIRST TIME - REFERRALS
02/16/04	(H)	HES, FIN
03/02/04	(H)	HES AT 3:00 PM CAPITOL 106
03/02/04	(H)	Heard & Held
03/02/04	(H)	MINUTE(HES)
03/04/04	(H)	HES AT 3:00 PM CAPITOL 106
03/04/04	(H)	Heard & Held
03/04/04	(H)	MINUTE(HES)
03/18/04	(H)	HES AT 3:00 PM CAPITOL 106
03/18/04	(H)	Moved CSHB 511(HES) Out of Committee
03/18/04	(H)	MINUTE(HES)
03/24/04	(H)	HES RPT CS(HES) 3DP 1DNP 2NR
03/24/04	(H)	DP: KAPSNER, CISSNA, WILSON; DNP: WOLF;
03/24/04	(H)	NR: GATTO, COGHILL
03/29/04	(H)	FIN AT 1:30 PM HOUSE FINANCE 519

03/29/04	(H)	Heard & Held
03/29/04	(H)	MINUTE(FIN)
03/31/04	(H)	FIN AT 1:30 PM HOUSE FINANCE 519
03/31/04	(H)	Moved CSHB 511(HES) Out of Committee
03/31/04	(H)	MINUTE(FIN)
04/01/04	(H)	FIN RPT CS(HES) 4DP 2NR 2AM
04/01/04	(H)	DP: MEYER, HAWKER, HARRIS, WILLIAMS;
04/01/04	(H)	NR: FATE, FOSTER; AM: STOLTZE, CHENAULT
04/26/04	(H)	MOVED TO BOTTOM OF CALENDAR
04/26/04	(H)	NOT TAKEN UP 4/26 - ON 4/27 CALENDAR
04/27/04	(H)	NOT TAKEN UP 4/27 - ON 4/28 CALENDAR
04/28/04	(H)	TRANSMITTED TO (S)
04/28/04	(H)	VERSION: CSHB 511(HES) AM
04/29/04	(S)	READ THE FIRST TIME - REFERRALS
04/29/04	(S)	HES, FIN
04/30/04	(S)	HES AT 1:30 PM BUTROVICH 205
04/30/04	(S)	Heard & Held
04/30/04	(S)	MINUTE(HES)
05/03/04	(S)	HES AT 1:30 PM BUTROVICH 205

WITNESS REGISTER

Mayor John Williams
City of Kenai Peninsula Borough
144 North Binkley Street
Soldotna, AK 99669
210 Fidalgo Ave., St. 200
Kenai, AK 99601
POSITION STATEMENT: Testified on CSHB 511(HES) am

Blaine Gilman
Attorney representing Lord's Ranch
Kenai, AK
POSITION STATEMENT: Testified on CSHB 511(HES) am

Jeff Kinion
CEO of Alaska Open Imaging Center
6911 DeBarr Road
Anchorage, AK 99504
POSITION STATEMENT: Testified on CSHB 511(HES) am

Doctor Val Christensen
Alaska Open Imaging Center
6911 DeBarr Road
Anchorage, AK 99504
POSITION STATEMENT: Testified on CSHB 511(HES) am

George Larsen
Valley Hospital
515 Dahlia Avenue
Palmer, AK99645
POSITION STATEMENT: Supports CSHB 511(HES) am

Brian Slocum
Tanana Valley Clinic Administrator
1001 Nobel Street
Fairbanks, AK 99701
POSITION STATEMENT: Testified on CSHB 511(HES) am

Mike Powers
Fairbanks Memorial Hospital
650 Cowles Street
Fairbanks, AK 99701
POSITION STATEMENT: Testified on CSHB 511(HES) am

Robert Gould
Fairbanks Memorial Hospital
650 Cowles Street
Fairbanks, AK 99701
POSITION STATEMENT: Supports CSHB 511(HES) am

Rick Solie
Volunteer Trustee, Greater Fairbanks Hospital Foundation
665 Knightsbridge Road
Fairbanks, AK 99709
POSITION STATEMENT: Testified on CSHB 511(HES) am

Doctor Kurt Hediger
AK Chiropractic Society President
Anchorage, AK
POSITION STATEMENT: Opposes CSHB 511(HES) am

Doctor Robert Bridger
Alaska Open Imaging Center
6911 DeBarr Road
Anchorage, AK 99504
POSITION STATEMENT: Opposes CSHB 511(HES) am

Paul Brenner
Central Peninsula General Hospital
250 Hospital Place
Soldotna, AK 99669
POSITION STATEMENT: Testified on CSHB 511(HES) am

Doctor Helen Bedder
No address provided
POSITION STATEMENT: Opposes CSHB 511(HES) am

Joel Gilbertsen, Commissioner
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Explained aspects of CSHB 511(HES) am

Janet Clarke
Department of Health & Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Testified on CSHB 511(HES) am

Doctor Chris Conover
Assistant Research Professor of Public Policy Studies
Box 90253
Duke University
Durham, NC 27708
POSITION STATEMENT: Testified on CSHB 511(HES) am

Charlie Franz
CEO, South Peninsula Hospital
Homer, AK
POSITION STATEMENT: Testified on CSHB 511(HES) am

ACTION NARRATIVE

TAPE 04-27, SIDE A

CHAIR FRED DYSON called the Senate Health, Education and Social Services Standing Committee meeting to order at 1:36 p.m. Present were Senators Green, Wilken, Davis and Chair Dyson. Senator Guess arrived momentarily.

CSHB 511(HES) am -CERTIFICATE OF NEED PROGRAM

CHAIR FRED DYSON announced CSHB 511(HES) am to be up for consideration. He recognized Kenai Mayor John Williams and asked how far along the two adolescent facilities projects were that he spoke about during the previous hearing.

JOHN WILLIAMS, Mayor of the City of Kenai, replied the city was in a land purchase process that began about three months ago.

Architects had already spent considerable time rendering drawings for the projects and he knew that both companies had spent considerable time in anticipation of the project.

CHAIR DYSON said he asked that because some of the committee members believe that it's a bit unjust to change rules in midstream so they were looking for some way to keep those companies from being subject to new rules. He suggested that he and others listening think about how they might grandfather in those people who had begun a process and made commitments without opening the door too wide.

MAYOR WILLIAMS expressed his appreciation and said he thought the commissioner was well aware of how many beds are needed as well as how many beds are planned and in progress. When they suggested a January 1, 2005 effective date during the previous meeting, he wasn't aware whether the date would or would not accommodate any other projects that might have been started, but there should be some leeway for accommodation.

CHAIR DYSON asked Mayor Williams to stand by and called on Mr. Gilman.

BLAINE GILMAN from Kenai said he is an attorney representing the Lord's Ranch, which is a non-profit based out of Arkansas that runs a residential treatment facility and an out-patient counseling facility. Both are for children.

The Lord's Ranch is in the process of trying to develop and build a 30 bed facility in Kenai. They started the process in November 2003 when they applied to purchase a piece of city property. They re concerned that if this legislation passes then they will miss the entire 2004 construction season. He asked the committee to think about the fact that they must still go through a licensing process so the department does have oversight over this type of facility. To date they have gone through re-platting, surveys, and an appraisal of the property and they really want to continue to move forward with the project. He has seen data indicating there are over 500 Alaska children in facilities outside the state evidencing the fact that there is a terrific need for this type of facility in Alaska.

CHAIR DYSON announced that he would like everyone to keep their remarks to three minutes because of the number of people that wanted to testify.

JEFF KENYON, CEO of Alaska Open Imaging Center, reported that he has been involved with the delivery of medical care for about 30 years. Four years ago he left hospital employment to become independent.

He said he has seen hospitals hold back on purchasing and installing new technology until competition spurred them to make the move. Valley Hospital is such an example. Although they were asked to consider installing a bone density unit to evaluate osteoporosis over several budgetary request cycles, they took no action until the service was offered by the competition. At that time it took just months for Valley Hospital to install the equipment.

PET scanning is one of the most expensive technologies there is and Providence Hospital was reluctant to bring a scanner in until a competitor did so. They offered Providence Hospital a "cost competitive, cooperative arrangement only to have the hospital negatively react and commit to a $2.8 million machine and duplicate the service, which by the way, was not CON [certificate of need] approved." Competition has benefited the people of Alaska and has increased the level of technology and care and competition works to decrease costs, he stated.

He charged that the Department of Health and Social Services (DHSS) in cooperation with multimillion dollar out of state hospitals are organizing for a double standard monopoly that will ultimately be very expensive for the citizens of the state. HB 511 is an effort to steamroller this process without giving legislators the time or information that would make it possible to analyze the facts to make a sound decision. "Competition drives the level and the delivery of health care up while driving the cost of health care down. Competition works where the CON was designed to, but never did," he concluded.

1:46 pm

SENATOR GRETCHEN GUESS asked Mr. Kenyon to explain how the CON might jeopardize competition if it's supposed to result in adequate capacity within a community.

MR. KENYON replied, "We don't feel that the delivery of the certificate of need in Alaska is a fair approach and equally represented to all companies." He said he understands that Providence Hospital has tremendous influence on both DHSS and the advisory board for CONs and they have tremendous influence

behind HB 511. Because of this, his company won't be allowed the opportunity to fairly expand and grow.

SENATOR GUESS interpreted that to mean that it's not so much the CON itself rather it's the current process of how CONs are applied that is problematic.

MR. KENYON didn't agree and advised that their philosophy is for free enterprise and competition to be the regulating force for which services are needed and which are delivered. Through the CON regulation process undue expense and time and unfair evaluations are the problem.

SENATOR GUESS asked how his business deals with the uninsured and the underinsured.

MR. KENYON replied their philosophy is to take care of the patient first and work out the details later. They work out individual payment plans and are also write off uncollected debts.

CHAIR DYSON added that he understands that they give a discount to those people who pay cash.

MR. KENYON said he thought there was a slight discount for prompt pay.

CHAIR DYSON noted that is in contrast to most facilities that charge 30 to 40 percent more for patients that pay their own bills [the uninsured].

DOCTOR VAL CHRISTIANSON said he is a board certified diagnostic radiologist who is currently working for Alaska Open Imaging Center. When he was in the Air Force he was the chairman of radiology and nuclear medicine at Elmendorf. He left the state briefly but after his retirement he moved his family back to Alaska because he thought he could make a significant contribution to the improvement of health care in Alaska. His commitment is based on the ideal of a free and open market for business competition and free enterprise. He continued:

> HB 511 definitely represents collusion with intent of restraint of trade and is the antithesis of the American free enterprise that we all believe in as well as our Alaska model of 'North to the Future.' It does indeed represent a giant leap backwards to the era of 'Might Makes Right.'

HB 511 guarantees monopolistic control in the medical imaging market with the two-tier price fixing system and essential gouging of the Alaska public. This is the business equivalent of telling John Dow he can't open the automobile repair shop because we already have a qualified Ford dealer or a qualified Chevy dealer in town who is sufficient, thank you very much.

In recent House testimony on Thursday night, Representative Samuels stated for fairness on the front end and sounded very good, but in reality it absolutely destroys fairness on the back end. What he didn't mention is from here on out a small independent facility would have no chance, essentially, to acquire new equipment or replace old equipment in a world dominated by hospital deep pockets and critical connections.

Previous to his final speech that night, a Representative from Fairbanks, who admitted to sitting on the hospital board up there, stated there is a 30 percent increase in the chance of errors including services of hospitals. He gave no documentation of that whatsoever, which is somewhat untenable without citation of a mainstream or a peer review study. There are indeed several big mainstream peer review studies published in the Journal of American Medical Association which has filtered down to the popular press such as Readers Digest that document very high and unacceptable errors in hospital services including radiology departments.

That Representative also stated that 33 states presently in the Lower 48 have a certificate of need program. What he didn't mention was that originally 49 of the 50 states had CON programs and that the federal administrators dropped the federal CON programs in the 1980s and the rest of the states have followed suit. These programs have been proven not to work down there.

He also stated that medical economics work differently and have been arguing against free enterprise. That is true. Medical economics have been shown to operate differently. What he didn't state was why. The main reason they work differently is because of a problem

of self-referral. Self-referral means that a doctor sees a patient in his clinic and refers that patient to his own imaging center or his own laboratory testing center. This is even worse if the hospital owns the equipment.

Alaska Open Imaging Center does not do this and cannot do this because our radiologists don't make that initial patient visit and don't control referrals. Independent outpatient centers do imaging more efficiently, more economically and with a higher standard of care. They are not subject to the cost of the CON, which can run up to $100,000 for the bureaucratic costs, all of which are passed along to the patients.

Independent outpatient centers are not involved in over utilization and inflated costs associated with self-referrals. It's my belief, and others also, the hospitals should stick to what they do best, which is inpatient care of critically ill people including any needed imaging. They should not attempt monopolistic control of all business enterprise especially in the outpatient imaging arena for the purpose of cost shifting.

HB 511 is being ramrodded through just as quickly as possible because the powers behind it do not want [indisc] to have time to read the studies or learn the facts behind it. It threatens my livelihood personally and I feel it threatens Alaska patients and payers on their behalf and everybody stands to lose big time with this.

SENATOR GUESS asked him to comment further on how he believes CON creates a two-tiered system because, "no matter what situation, you're not going to have perfect competition in medical economics. You're always going to have oligopolies." She assured him she wasn't trying to give him a hard time she was simply trying to understand how a CON would deny him his livelihood.

DOCTOR CHRISTIANSON replied one of their findings is that there is a two-tier system between inpatient hospital pay for Medicaid and Medicare as opposed to outpatient. As far as the impact on his livelihood, he said that if his company wanted to purchase a very expensive piece of equipment for one of their facilities

and they weren't already in that market place but a hospital was, it would be difficult for them to justify why they should have the equipment instead of the hospital. Another point is that when it comes time for them to replace a piece of equipment, such as an MRI, Providence Hospital is right there and has the certificate of need so there is no way they could compete for a new CON to replace the equipment. "We would basically go out of business at that point," he said.

CHAIR DYSON recognized George Larsen in Mat-Su.

GEORGE LARSEN stated that he supports the bill as presented.

He noted that there have been references to Triad having deep pockets, but he clarified that the community and Triad have had a joint venture that was established because Valley Hospital wasn't able to generate sufficient money for replacements.

Imaging is one of the areas in which a hospital can make some profit and provide an offset to areas such as emergency rooms that draw down the entire organization. If they couldn't rely on imaging to generate profit, they would have to rely more heavily on the state, he said.

CHAIR DYSON asked him if he works at Valley Hospital.

MR. LARSEN replied he is the chief executive officer at Valley Hospital.

CHAIR DYSON asked him to clarify whether or not he just represented that Valley Hospital charges more for imaging than the service costs to offset services that don't pay for themselves.

MR. LARSEN replied, "That is true and that's where we're charging a little bit more. It's competitive with the market in Anchorage." If they weren't able to make a profit on imaging and offset losses in departments like emergency rooms, medical surgical units, and obstetrics they wouldn't be able to operate. They look at the full system rather than the separate parts, he said.

CHAIR DYSON asked how much discount on imaging services they give third party payers such as insurance companies over a self-payer.

MR. LARSEN said he would have to go to his billing department to get that information for certain, but he thought that with Medicare and Medicaid they receive in the neighborhood of 50 to 55 percent of the bill. On the other hand, he said, they give discounts to self-payers in the form of write offs. In 1999 they wrote off $2.9 million, in 2000 they wrote off $4.6 million, and in 2001 they wrote off $4 million.

CHAIR DYSON restated his question, which was what discount they give insurance companies.

MR. LARSEN said Medicare and Medicaid pay 50 to 55 percent so the receive a 45 or 50 percent discount. Blue Cross Blue Shield receives between 3 and 6 percent off charges he said.

SENATOR GUESS asked why they couldn't price services to make a reasonable profit in the departments that lose money so they wouldn't have to overcharge in departments that do make money.

MR. LARSEN said some of it has to do with the market. In the medical surgical unit a room costs over $1,000 per day and they believe they're priced at what the market can bear.

BRIAN SLOCUM, administrator of the Tanana Valley Clinic in Fairbanks, reported that they are the largest multi specialty group in the state and they too provide care for indigent patients. In 2003 this amounted to about 4.6 percent of their net revenue and he knew that Fairbanks Memorial Hospital reported that about 1.8 percent of patient revenue was uncompensated. Contractual adjustments for Medicare and Medicaid amounted to another $5.6 million for the clinic, he said.

He said his point is that the CON application in Alaska needs revision because it's fatally flawed and has outlived its usefulness. In 1999 his clinic was turned down when they applied for a CON. During a subsequent appeal, depositions uncovered a number of precepts. First, the CON program has no risk standards that are used to evaluate applications. According to sworn testimony, DHSS used to employ 25 people for planning and CON review. Now there is a single person and they aren't able to provide current updates of CON standards for a review. He pointed out that even multi million dollar projects have no written standards to use for evaluation purposes.

He was aware that the CON coordinators assured Senator Green that confidentiality is provided when competing applicants file multiple CON applications simultaneously. However, in sworn

testimony the CON coordinator admitted that he sent application data from the Tanana Clinic to Fairbanks Memorial Hospital and other CON applicants for editing. Although his company protested, their objections were ignored.

Finally, he pointed to a CON review dated February 10, 2004 in which the coordinator decided that a CON would be required for a group of physicians because the present value of the equipment they were applying for exceeded $1 million. Although it's been stated multiple times that hospitals want to level the playing field because doctors don't need a CON when leasing equipment, the CON coordinator apparently anticipated the Legislature and changed the requirements. "This is all too characteristic of the CON program," he said.

MIKE POWERS, administrator of Fairbanks Memorial Hospital, testified via teleconference to say that he would like to speak to the philosophic issues of CON and comments about them restricting competition and being a monopolistic control measure. "A number of things have been said about the unique rules of health care economics. They essentially require four conditions to be met. Buyers and sellers are well informed, buyers and sellers are numerous, buyers and sellers are independent and there is easy entry and exit from the market." Not one of those conditions is met in health care. Patients make infrequent decisions about health care issues and so are not informed. There are many sole community providers and so there aren't many buyers and sellers in a community. The whole role of insurance puts a barrier between the buyer and seller. If Fairbanks Memorial were to try to exit from the ER or neo-natal market, there would be public outrage. Because those basic conditions aren't met there's a need for some kind of regulation.

The question of cost subsidies is anathema to business, but departments such as the ER are badges of honor to a hospital. "We're proud of the ER and we're proud of taking care of burns, neo-natal, Medicare and Medicaid and all comers." However, he said he takes issue with niche providers that cherry pick labor in an 8 to 5 operation while the hospital operates all hours to take care of the entire community. Empirical evidence suggests that niche providers target less costly patients, which raises the issue of a few shareholders benefiting versus access to many in the community.

Questions about ethics and self-referral have come up, but the federal government is calling for an 18 month moratorium as a

result of the adverse impact of niche providers. A General Accounting Office study in Florida shows that doctors that own diagnostic imaging equipment charge 54 percent more for Medicare scans, 28 percent more for CT scans, and 25 percent more for ultrasounds. The study indicates that 83 percent of all specialty hospitals and 55 percent of general hospitals are located in states without certificate of need. Some states are moving back to CON because they found that managed care in the 80s and 90s didn't work.

In conclusion he said they would like the committee to conceptually make the rules fair for all organizations.

SENATOR GUESS asked him to comment on what keeps Fairbanks Memorial Hospital from pricing ER services to reflect the costs plus a reasonable profit.

MR. POWERS replied it's the heavy reliance on the government payers such as Medicaid and Medicare that don't pay for the cost of the care. Those costs have to be recovered somewhere else so you over price in other areas.

CHAIR DYSON commented that that is a remarkable statement.

MR. POWERS replied, "It's a sad, unfortunate societal dilemma that unfortunate legislators find themselves in and can't fully fund the Medicaid program."

CHAIR DYSON asked if he just said that because Medicare and Medicaid reimbursements don't cover the cost of services you have to put those charges on somebody else and that is either the self payer or the insurance third party payer.

MR. POWERS replied, "All costs, all charges are placed equally on all payers it's just that some refuse to pay for those."

CHAIR DYSON said that includes Medicare and Medicaid.

MR. POWERS agreed.

SENATOR GUESS questioned whether the prices charged in the ER are reflective of the cost of services plus a reasonable profit.

MR. POWERS said they are.

ROBERT GOULD reported that he is the associate administrator of finance and operation [for Fairbanks Memorial Hospital] so he

fills the CFO role and also has operational responsibility for imaging, surgery, ER etc. He said he supports the bill because, in his view, it levels the playing field, which is not currently the case.

Using imaging as an example he advised that the hospital is in the process of building an imaging center and they are restricted to building up to the current community need. They are unable to build in extra services or build for anticipated growth, but a business without a CON could come in and draw business away from the hospital without going through the CON process. Although there have been charges that this restricts competition, the fact is that anybody that goes through the CON process that can show need can get approval for their project. "The fact of the matter is that if there is capacity in Fairbanks, even after we're done with our imaging center, someone else could come in, apply for a certificate of need and as long as they can show need, they can have the services. Under the current legislation, the way it is now, for imaging it isn't required. They could just build on top of what we've already built and shown a need for."

He said he would challenge the statement that a CON can cost up to $100,000 because they've done a number of them and if they've spent more than $10,000 on any one he would be very surprised. He also challenged the idea that Fairbanks Memorial Hospital is a monopoly and that they don't foster competition. If competition brings lower costs then the costs in Anchorage should be the lowest in the state, but Fairbanks Memorial Hospital is actually the low cost full service provider in Alaska.

He stated that there are four areas in health care that pay. Whether it's right or wrong, Medicare, Medicaid and other payers have placed a premium on imaging, surgery, pharmacy and lab services. Those are the only services a hospital would provide if they were in business solely for the money because those are the only services in health care that make the money needed to sustain the facility.

CHAIR DYSON remarked that when he said that the hospital builds capacity up to the need he assumed that it meant the need of the people in the area, but he probably meant the need as defined in the CON.

MR. GOULD replied when they applied for a CON it was to fill the needs that they thought they could support and that weren't being met.

CHAIR DYSON asked if that was the need that was defined in the CON.

MR. GOULD said that when they applied for the CON it was to fill the need they thought they could support related to the needs that were not offered in the community at that time. "What I meant is that we were building up to what we believed the customers in Fairbanks need at this time. What we could justify based on the numbers."

CHAIR DYSON acknowledged that they were both looking at and using the numbers in the same way. He asked whether it's legitimate for someone else to come along and meet a need that the hospital didn't recognize.

MR. GOULD asked what that might be.

CHAIR DYSON said it would be someone else offering the same service and meeting needs that Fairbanks Memorial Hospital didn't have the capacity to meet. "You object to them coming and taking the new business?" he questioned.

MR. GOULD replied he wouldn't object to that, but he would object if they went through the CON process to show need for two MRIs only to have someone else enter the picture and began taking business away from the hospital by offering MRI services without going through the CON process.

SENATOR GUESS asked why he believes the four areas he mentioned are profitable because they heard that prices are under cost but they're all the market can bear. Also, they've heard that it's really recovery and not prices that are under cost.

MR. GOULD explained that Medicare reimbursement is higher in those four areas and most providers elect to use the Medicare regulations to determine reimbursement. Charges, he added, are becoming less relevant in health care because Medicare and Medicaid give a flat fee in each area. For instance, Medicaid reimburses Fairbanks Memorial Hospital 52 percent of charges and Medicare reimburses 50 percent of charges.

RICK SOLIE, volunteer trustee on the Greater Fairbanks Hospital Foundation, stated this is a very important issue for their

community hospital. He said he would first clarify several issues he heard during the hearing on Friday.

The foundation contracts with Banner Health System to run the hospital for about 3.5 percent, which is average to low for this service. The notion that Banner Health is making a great deal of money from this contract is not accurate or fair. ".... health care and hospital economics is not a free market and so to employ the standard of free competition on it is not fair because it isn't true. What is true though, is to have a rigorous discussion of some of the benefits that competition gives you and that is cost quality and access."

TAPE 04-27, SIDE B
2:21 pm

Specifically as it relates to Fairbanks:

> We're trying to help our communities and trying to have imaging systems and in Fairbanks we're working hard on a cardiology program trying to figure out a way to make that work. We have audited statements from Medicaid rates that show our hospital with the lowest inpatient rates. That's across the board, that's the overall picture.
>
> On the outpatient side, our hospital has lower rates than Anchorage on the outpatient side. And this is a town that you would argue doesn't have competition, yet our prices are lower. Specifically on the MRI, - I can't speak to Anchorage I know [Alaska] Open Imaging is touting cheaper prices - I know our experience in Fairbanks is that the MRI prices at our hospital are between 20 and 40 percent lower than those at the clinic across town. So I would suggest that competition in whatever form you might call it is not bringing lower prices in Fairbanks. What it does do is hurt our ability to provide those services like the ER, the neo-natal care, the psychiatric care, the cancer care - an awful lot of those things that we look to. I would encourage the committee to be careful as you look at this bill because we don't want to start to take apart a system that at least in Fairbanks we've spent some 34 years in building.
>
> We support this bill. I think it closes up the lease provision and the diagnostic provision. It creates a

level playing field. You can argue about the wisdom of the CON. [But] honestly, I don't think this is the day to do that. This is a better day to at least create a level playing field and let's have some discussion about whether it's deductibles or medical savings accounts or ways to move a free market into the health care sector. But it is not a free market today so on cost - and I didn't even get to quality and access because my time ran out - we have 98 percent board certified medical staff. We take all comers and I would be happy to answer questions.

SENATOR GREEN asked for his interpretation of what the new language does for the lease issue and how it differs from the current situation.

MR. SOLIE said that's in Section 2 and his understanding is that under current law it would allow for an ambulatory surgery facility to be constructed if the facility was leased or the equipment was leased. He wasn't clear on the monetary total, but "it's the lease provision that allows for the skirting around the CON need."

SENATOR GREEN wondered whether his reference to lease was a specific reference to Fairbanks Memorial Hospital.

MR. SOLIE replied it is specific because under current law there are two ways that it doesn't apply uniformly. Those are diagnostics and the lease provision. This bill would level that playing field, he said.

SENATOR GREEN asked whether Fairbanks Memorial Hospital had ever leased facilities.

CHAIR DYSON added, "Or equipment."

MR. SOLIE advised the foundation leases the hospital to Banner Health System and they pay the hospital a lease fee. He said he wasn't sure whether that answered the question.

CHAIR DYSON said that in Section 2 he understands that there is a $1 million threshold and if you're under that amount you wouldn't have to go through the CON process. Some people have figured out that you could lease the equipment so that money comes from the operating budget and you stay under $1 million.

Those that believe that the lease issue allows unfair competition, say that loophole should be closed. Senator Green just asked whether Fairbanks Memorial ever leases equipment.

SENATOR GREEN added, "Or anything."

MR. SOLIE said the foundation isn't leasing any real estate and he would have to defer to the finance officer regarding the leasing of equipment. Their concern is that whether or not you like the CON, it doesn't apply to the ability to build a facility or obtain equipment through a lease mechanism.

SENATOR GREEN asked whether the foundation ever leased anything to the hospital that didn't go through the CON process.

MR. SOLIE asked whether she was speaking of the cancer center.

SENATOR GREEN replied she didn't know anything about his foundation.

MR. SOLIE explained the foundation is the owner of the facility and the equipment. Generally the hospital applied for the CONS, but sometimes the foundation has assumed that role.

SENATOR GUESS said she would like to spend time on Section 2 at some point because 'purchasing equipment' isn't referenced under 'expenditure'. It's just leasing that is referenced.

CHAIR DYSON agreed with her reading.

SENATOR GUESS asked that the sponsor's staff explain why you wouldn't need a CON if you purchased $1 million in equipment, but you would if you lease the equipment.

CHAIR DYSON said the department could speak to it, but he thought that since you wouldn't have to go through the CON process if you were under $1 million, people were avoiding that threshold by leasing equipment.

DOCTOR KURT HEDIGER, AK Chiropractic Society President, testified via teleconference to say he practices throughout the state as a vacation chiropractic physician and is opposed to the bill in its current form.

Although the CON may have been necessary at some point, it's a dinosaur in 2004 and the $1 million threshold is low in today's dollars. The bill would negatively impact his patients and his

business and would give an edge to established health care facilities and stifle upstart businesses. It appears to be anti competitive and amounts to government support for the status quo. "The consumer will continue to have limited choices and health care costs could only go up as quality and patient satisfaction actually will decline."

To his knowledge, just Fairbanks Memorial Hospital has restrictions against chiropractic referrals and such impedance to access is frustrating because it delays treatment, increases costs and puts the patient at risk. Alaska Open Imaging increases capacity and choice for Mat Su, Kenai and Anchorage. The focus should be on the patient's best interest and that is competitive health care through competition accessibility and the use of innovative technology. He emphasized he believes that including "independent diagnostic facility" is wrong.

With only one provider you can't expect prices to go down. With that in mind, he questioned how hospitals made a profit before imaging like MRIs and CT scans. All businesses assume risk but if this bill passes, hospitals in Alaska will have their profit margin protected by statute.

CHAIR DYSON asked what he believes a reasonable threshold to be if the $1 million is too low.

DOCTOR HEDIGER suggested it should be adjusted for cost of living increases and could be five times the amount it is for larger businesses.

DOCTOR ROBERT BRIDGES from Alaska Open Imaging Center testified via teleconference that he started the business in 2001. Countering the claim regarding over charging on self-referrals, he said can't self-refer. His work is always returned to the referring physicians so if he does a good job and the patient is happy he may get the next referral. His work undergoes peer review every day for every procedure and provides a form of checks and balances.

When the business first opened in Wasilla, they had an open MRI magnet just like the one at Providence Hospital. Later they added a CT scanner that was similar to the one at Providence. Seven months later Valley Hospital fired the radiology group that had been working there for 17 years because the hospital could have been offering these services all along, but they didn't because they didn't want to or they didn't know how.

When his business moved into Anchorage they added another open MRI scanner because Providence had abandoned open imaging and their patients had to go to Wasilla for a scan. Next they added a CT scanner and finally in March 2003 they installed a Positron Emission Tomography scanner. As board certified in nuclear medicine and a nuclear engineer he said they were very qualified to do this.

Providence Hospital talked about installing a PET scanner for five years and for three years they could have done so. Referring to their CON application for renewal in December 2002, he said they admitted they had done nothing on this project but they needed a renewal because the price had ballooned to $4.5 million. "Providence followed in our footsteps and using their taxed for profit wing, legally circumvented the CON and leased a $2.8 million PET scanner that fits in a mobile trailer behind the hospital. It could be done. We did it because we took the time, we knew what to do and we delivered on this, much needed services."

He said his business takes care of Medicare and Medicaid patients and patients that are difficult because of their size and/or claustrophobic tendencies yet the hospital says they cherry pick. The CON won't work, he said, because it restricts access to the equipment he needs to practice medicine and it restricts patient access. The CON does not help Valley Hospital because people can vote with their feet, get in a car and go to Anchorage. "Before we came on the scene, half of all the outpatient and daily medical services in the valley were going to Anchorage. .... People want choice, they want an opportunity for better more diversified medicine in the state."

The playing field is already equal, he said. Using the CON is capricious and will bring waste and cronyism.

UNIDENTIFIED SPEAKER commented that someone said that outside corporations were making money in Alaska and she would point out that Providence arrived in Alaska in 1905. With reference to the charge that hospitals are monopolistic, she said we're really talking about what is best for communities. Senator Guess has been asking about competition and the services that aren't self-supporting. People can and do vote with their feet as the previous speaker pointed out, but it's hospitals that are open all hours of every day and every night and the public expects full services to be available in the hospital. To do that, the hospital has to have the ability to provide those services.

As Mr. Gould said, there are four areas that are profitable and facility providers don't control that. Medicare and Medicaid and someone up in federal offices decides what they believe is important. Imaging is an important area and therefore provides an opportunity to support areas that aren't profitable.

In conclusion, she said she hopes the committee can support the bill.

PAUL BRENNER, vice president of quality management at Central Peninsula General Hospital, said he supports the bill. The CON has worked for many years and guarantees a level playing field. It will help eliminate duplication of services in small communities and help curtail rising medical costs.

DOCTOR HELEN BEDDER testified via teleconference to say she is strongly opposed to CONs and most physicians are opposed as well. She reminded members that Alaska has few restrictions on physicians, which is one reason why doctors are attracted to the state. CONs are restrictions on the ability to practice. All the hospitals are talking about CONs leveling the playing field, but she doesn't see why hospitals believe they play on a level field because most of them are non-profit. Hospitals receive a percentage of what they charge from Medicare and Medicaid while independent surgery centers are paid a flat rate that is set by Medicare and Medicaid. The result is that hospitals are paid higher. Hospitals have a natural advantage in terms of referrals that independent practitioners don't have.

With regard to the question Senator Guess asked about how CON shuts down competition, she pointed out that a Fairbanks physician applied for a CON only to have Fairbanks Memorial Hospital take away his hospital privileges, which eliminated his ability to earn a living.

SENATOR GUESS asked if she believes that it's the CON process that's the problem rather than the CON itself.

DOCTOR BEDDER replied she really doesn't believe the concept itself is fair, but the process definitely isn't fair. CON was initiated years ago as a federal program to determine how costs and charges were determined. Most states have done away with CON because it's no longer part of what is needed to determine costs. The CON in Alaska is archaic and is being maintained by Providence and Fairbanks Memorial in an effort to control the market and make sure there isn't any competition. Competition works and reduces prices.

CHAIR DYSON asked the commissioner to come forward.

JOEL GILBERTSEN, Commissioner of the Department of Health & Social Services, introduced himself and asked Janet Clarke to sit with him. He said:

> There have been a number of things stated today and I think it's fair to say that there have been different perspectives put on issues by organizations. As the State of Alaska it's not really our business to pick amongst providers. We want to make sure we have a fair process. I know there have been criticisms of the process around certificate of need and I think it's fair to say the department has to work continuously on a daily basis to improve that process. That said, as an administration, as a department, we support this legislation.
>
> The legislation touches upon a number of issues, one of which I wanted to speak to, which is residential psychiatric treatment center care. Right now we are engaged in an effort called, "Bring the Kids Home." Bring kids home from out of state and these are kids with residential placements out of state because of a lack of continuum care including residential placements in state. We believe we can serve these kids better here in Alaska. We believe it's better for them therapeutically, but it's also better policy.
>
> What we also know is that while there might be 400 plus kids in residential placements out of state, we do not need 400 beds in state. In fact we believe our system rushes children into residential placements because we haven't had the continuum of care. We haven't had a good gate keeping system. We don't have good therapeutic foster care programs and group homes. We need to invest in these things. They are cheaper than residential care and they're better for many of them.
>
> As we engage in this effort to bring these children home we want to make sure we have a system that is geographically responsive to the needs of the children. But is also acknowledges that we have to have the appropriate amount of beds in state. Certificate of need does have its critics and

supporters. I support CON; I think it's a good way for a state to have a public process and in turn give adequate access to care across the state.

I know there have been comments around competition. Competition brings a lot to many different markets. I think for health care, competition greatly increases choice and choice for the consumers. Does it necessarily benefit cost? Not in all cases. In some cases it does but not in all cases. One of the things we have in health care and are painfully aware of - I know the Chairman is aware of this because I've had conversations about this with him - but outside of the cash payer, most individuals really do not select their health care or the location of their health care based on cost. There is an intermediary between the price and the consumer. It's called insurance. Some times it's provided by the State and sometimes by their provider, but they do normally shop not based on cost but on access.

Quality is a key component when making their choice. Who has the better facility? Location, convenience other amenities, but not necessarily cost. So we do have some concerns about as we move forward and supporting CON policy that we're developing this residential system in state that is cost efficient, that the state the primary payer. And for these kids we are the payer. Particularly after 30 days of residency status.

The other provisions we support and I want be here with Janet to answer questions of the committee or to comment on things that you may want to hear from us.

CHAIR DYSON said he had a couple of questions beginning with page 2, line 3. He questioned why they should care how many times a business or person relocates their capacity in an area.

Janet Clarke with the Department of Health & Social Services said they brought an analysis of Sections 1 and 2 from the assistant attorney general who advises them on CON. She said he could join them at the table if the Chair would like.

CHAIR DYSON said that's fine, but it's a philosophical question. Who cares whether they move every day as long as they're in the area and providing the service, he questioned.

COMMISSIONER GILBERTSON said it's fair to ask as long as the size and scope of practice remains the same and the geographic location is the same. The state's primary concern with certificate of need is whether or not that capacity is needed.

MS. CLARKE said current law doesn't allow that.

CHAIR DYSON said he knew that, but the philosophical question remains. Why is just one move allowed?

MS. CLARKE suggested the sponsor might want to answer that question.

CHAIR DYSON then asked for comments on whether the $1 million threshold is obsolete.

COMMISSIONER GILBERTSON replied it's a fair question, but when you look at the purpose of what CON is serving that threshold is as proper and relevant today as when it was originally designed. Originally CONs were for hospitals and nursing homes. Costs in those facilities have increased a great deal and if CONs were only addressing those facilities then the threshold isn't as valid, but it's not completely invalid. Hospitals are now competing in a different area. It's not about constructing a hospital it's about purchasing equipment so the threshold is still legitimate.

Now there are areas of new services such as ambulatory surgical centers and residential psychiatric treatment centers. He said these are boutique services that provide clearly defined services, but aren't of the broad scope that a hospital would provide. For those smaller facilities the $1 million is a viable threshold. As the market has changed and as hospitals have begun to provide other services the threshold is correct.

CHAIR DYSON asked about when a facility just leases a building as Fairbanks Memorial is doing.

COMMISSIONER GILBERTSON explained, the legislation is an effort "to ensure that whether you are purchasing it or you are leasing it, if you are acquiring for use for health care service, property with a value of over $1 million in its present day value, or equipment, that should be equally treated under the certificate of need law." This bill clarifies that, he said.

CHAIR DYSON announced that Doctor Conover was waiting to give testimony and since he was removed from Alaska by several time zones he would like to allow him time to testify.

DOCTOR CHRIS CONOVER, assistant research professor of public policy from Duke University, testified via teleconference and advised members that he and Professor Sloan conducted two studies of CONs for Delaware and Michigan. He stated:

> There are three principle reasons used to justify CONs that have been discussed - quality, access and cost. The chief one is cost, but then people often talk about quality and access.
>
> Our report from Michigan systematically refutes the evidence regarding CONs from every public CON study to date. Included among these were six studies that looked at CON's impact on the diffusion of CT scanners and four studies focused on CON's affects on the supply of MRIs.

DOCTOR CONOVER advised that he would submit the information for the record rather than going through each study individually. He then continued to say:

> On the CT studies, there was one study written by proponents of CON who in their study acknowledged that there were probably some very real non-economic patient costs of the Massachusetts approach to rationing scanners. These may have included long waits in addition to the inconvenience and discomfort of having to be transported from a hospital without a scanner to a hospital with one. They also noted that since limited availability of scanners forced prioritization of patients, some patients who might have benefited from CT were not scanned. Many of the alternatives to scanning involved more risk and discomfort to the patient such an angiography.
>
> A critical shortcoming of all of these studies is that they count the number of units rather than directly measuring the impact of CON on cost. This is somewhat equivalent to estimating consumer expenditures on gasoline based on the number of available filling stations. The presumption in these studies is that more units mean more services, which translates into higher costs. But the example of gas stations

illustrates the potential fallacy of that approach. In the case of gas stations, prices tend to actually be lower when there are two gas stations competing across the corner from one other. Even though, logically, one might think the duplication of facilities would result in higher prices.

While medical care is not the same as gasoline, various FTC studies have shown that hospital prices and costs are higher in areas where there is a monopoly provider compared to areas where there is head to head competition, which is precisely why the FTC regulates hospital consolidation - to prevent anti competitive affect.

Moreover, even if one could demonstrate that reducing the supply of imaging services results in lower spending on these services, this is not tantamount to proving that regulation has saved you money. On the contrary, if imaging is a substitute for more expenses, more invasive procedures and/or growing imaging can reduce [end of tape]

TAPE 04-28, SIDE A
3:06 pm

It is worth noting that there are no volume benchmarks for CTs or MRI services established by either the Joint Commission on Accreditation of Health Care Organizations or the American College of Radiology. So even if CON were effective in holding down the supply of CT or MRI services, there is no good reason to suppose this would confer an improvement in quality of care.

A final thought worth considering is this; only 21 states now regulate CT scanners, 24 regulate PET scanners and 30 regulate MRIs. Of the states that opted not to regulate these technologies, [did they make] a foolhardy choice? Are their citizens paying higher costs for enduring levels of quality care because these images do not now fall under CON review? I am aware of no such evidence. Unfortunately, the kind of definitive study that could nail down the answer to the question that will basically be considered by the committee today has not been done. Such a study is feasible and could be completed in

roughly a year's time. Frankly, given the availability of this evidence, I myself would be more inclined to drop regulation of imaging technology in-hospital than I would be to expand this regulation to non-hospital entities. The best approach of all might be to do the research that could definitively nail down this question of whether regulating these technologies saves money or adds to cost once all costs are taken into account. It is not at all clear what harm would be done by deferring a decision so the answer to the right question can be determined.

CHAIR DYSON asked Doctor Conover to FAX a copy of his research paper and his written comments and he would distribute copies to the committee members. He questioned whether he knew of any states that had particular success in handling these issues and whether there were paradigms available that Alaska might find useful.

DOCTOR CONOVER replied the states they worked for looked at CON globally and didn't specifically focus on imaging technology. Michigan asked them to look at MRIs so they did address them in their report. The evidence on MRIs is mixed, but they were all focused on hospital based MRI units and half of the MRIs that are in use are outside hospitals.

SENATOR GUESS asked if he is recommending that they eliminate imaging technology from the CON process rather than expanding the CON process to include them.

DOCTOR CONOVER replied if the committee feels compelled to take action he believes it would be preferable to level the playing field by taking away regulation in a sector rather than adding it to a different sector.

SENATOR BETTYE DAVIS asked whom he was representing.

DOCTOR CONOVER said Sam Corsmell contacted him, but he didn't know which facility he runs.

CHAIR DYSON assured him his question wasn't pejorative, but he wanted to know whether he was remunerated for his testimony.

DOCTOR CONOVER said he was compensated for his time to appear.

SENATOR DAVIS announced that she had a question for the commissioner.

CHAIR DYSON said he did too and if she didn't mind, he would go first. He questioned whether the major reason for the legislation didn't relate to the expansion of adolescent facilities and the desire to get them in under the CON process.

COMMISSIONER GILBERTSON said Representative Samuels introduced the legislation and DHSS began working with Representative Samuels' office after he had introduced the bill. They support the entire bill, but the department is most interested in the RPTC language.

CHAIR DYSON asked whether the present licensing process would allow DHSS to issue a directive saying they would only license so many beds in a certain area.

COMMISSIONER GILBERTSON said no; licensing is based on strict standards of meeting the clinical requirements for a facility. Right now there is a cap on long-term care beds, but that's done through the CON process.

CHAIR DYSON brought up his concern about the people who already started the process in Kenai and asked if there was a way to lend certainty to their process so they don't lose the construction season.

COMMISSIONER GILBERTSON interjected that he didn't know enough about the proposal to say with certainty that they could or could not make this construction season. "That said, there are - based on just informal communications - since there is no CON process right now, providers are not required to come to the state and let us know what you are planning. A number have voluntarily to say, 'These are things we're considering.' If you were to add all of them up, I think we have easily seen between 500 and 600 beds that are at some conceptual stage or closer to development in the state right now."

DHSS has developed a policy for interpreting the effective date for projects that are underway or have reached some level of decision-making within the organization. The policy is that projects are grandfathered in as long as legitimate construction has started, a full set of architectural drawings are completed and that the entity that is building the facility has a building permit in hand. In addition, they must complete construction within two years of breaking ground. It doesn't mean that everyone will get in, but they are putting the CON process

forward so that as psychiatric treatment center beds are brought on line in Alaska the kids' needs are met first.

SENATOR DAVIS asked if it was the sponsor's idea or his to put adolescent psychiatric treatment centers under the CON process.

COMMISSIONER GILBERTSON said they had a process underway to look at statutorily expanding, through a governor's bill, residential psychiatric treatment centers. Representative Samuels introduced his legislation first so they began working with him using a committee substitute on the House side.

SENATOR DAVIS asked if most of the 500 some children that would return to the state would be located in south central Alaska.

COMMISSIONER GILBERTSON replied the children in out of state placement are disproportionately Alaska Native and they come from rural communities. Simply based on the population of Anchorage, the need for residential facilities would be weighted in that community if the sole desire were to have the children close to home. That isn't always the case though, and there are always a variety of clinical reasons for why a child is placed in a certain place. "Our goal largely is that we want to have the care given as close to home as possible with the acknowledgement that it's a continuum of care and that there are levels of care below the semi-secure residential treatment center. And as the child is working their way back to their community, you want to make sure that they have the after-care and the support services in every community for the kids."

SENATOR WILKEN asked if there was a letter of intent with the legislation.

MS. CLARKE replied the House adopted a letter of intent that related to CON. It establishes a task force to look at the process and the procedures and standards to improve the effectiveness of the program. The letter of intent also indicates that the Legislature urges DHSS to expeditiously update the CON regulations, which is what Senator Green has mentioned many times.

SENATOR WILKEN asked for a copy.

SENATOR GUESS asked how she would learn more about the process by which they make a decision. After reading through the regulations and the statute, she was still uncertain about what evaluation methods are used and how a final decision is made.

COMMISSIONER GILBERTSON acknowledged the question is very appropriate. The State is currently in the process of finalizing an actual process for defining the criteria for this type of facility, he said.

MS. CLARKE added the statute requires them to look at need. Although no written standards have been adopted in Alaska, they are in the process of developing them.

CHAIR DYSON asked Mr. Franz from Homer whether he could give his testimony on Wednesday.

CHARLIE FRANZ said he wouldn't be available then, but his testimony wouldn't take long.

CHAIR DYSON told him to go ahead and apologized for keeping him waiting for so long.

MR. FRANZ stated he is the chief executive officer of South Peninsula Hospital in Homer and the chairman of the board of directors of the hospital and nursing home association and he serves on the DHSS assembled task force to look at developing standards for the CON process. "With that background, I would like to speak to you in favor of HB 511," he said.

It's a good bill that helps to preserve access to a full range of hospital-based health care, he said. It does this by including the independent diagnostic and testing facilities, which levels the playing field and gives equal treatment under the law. Independent diagnostic facilities would have to demonstrate a need instead of simply opening a facility and competing for these lucrative services that hospitals provide.

He took issue with the argument that independent diagnostic testing facilities are only an issue in larger communities. He pointed out that Homer has that problem.

CHAIR DYSON thanked all the participants and encouraged the committee members that were interested in offering amendments to get them drafted quickly and distribute them to other committee members and the administration so they could move the bill forward.

MS. CLARKE pointed out that she distributed a letter dated 5/3/04 providing the information requested of her at the previous meeting.

CHAIR DYSON thanked her and adjourned the meeting at 3:28 pm. CSHB 511(HES) am was held in committee.